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San Diego, CA 92130
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Attorney for Respondent, ADAM F. DORIN, M.D.

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against	Case No. 800-2013-000930 OAH No. 2015120747
ADAM F. DORIN, M.D.	DECLARATION OF DUANE A. ADMIRE IN OPPOSITION TO NON-PARTIES MOTION FOR ORDER RE INJUNCTION; WRIT OF POSSESSION AND/OR PROTECTIVE ORDER
Respondent.	Motion Hearing Date: 8/26/16 10:30 am

I, DUANE ADMIRE, declare:

1. I am an attorney licensed to practice before the courts of the State of California. I am an attorney at the law firm of Admire & Associates, attorney for Claimant, in this action and have personal knowledge of these facts. If called upon to testify, I would testify as follows:

2. All of the statements in the attached Opposition to Motion for injunction; writ of possession and/or protective order are true, except as to those matters stated on information and belief, and as to those matters, I believe them to be true.

3. On Saturday May 7, 2016, after receiving a request from KPBS reporter Cheryl Clark asking me to specifically tell her how many video clips Sharp had showing Dr. DORIN removing drugs from the carts, I began again reviewing Sharps discovery more thoroughly. Prior to May 2016, I had only reviewed items from the Attorney General's office and very briefly the material Sharp had produced along with the thumb drive of videos—I may have started reviewing the videos at times, but never to any real extent and had not taken any notes.

4. Upon receiving Sharp's discovery on November 11, 2015, on that very day, I did provide a copy of Sharp's response to our subpoena (which included a copy of the videos and documents) via email to my client Dr. Dorin and my law partner Dr. John Alexander, M.D., J.D. Sharps response to our subpoena, was uploaded on my work and laptop computer, both of which have multiple online and local hard drive back-ups. I only recalled that I emailed them the contents some days after giving back the drive to Ms. Carder and then went back through my emails to confirm that I had in fact on November 11, 2015 copied sent a copy to my client and law partner.

5. On May 7, 2016, in an attempt to respond to Ms. Clark's questions, as well as to thoroughly go through the evidence against my client, I began watching the video clips Sharp had produced and taking notes on what they contained. The task was monotonous as there was no way to easily fast forward through the clips on the video viewer I used, so I simply skipped through them, mainly concentrating on anybody who was near the anesthesia cart, looking for evidence that could be used for or against my client.

6. During my review, I noted multiple occurrences of what I believed was exculpatory video evidence. I also came upon a clip that didn't appear to have Dr. Dorin as one of the doctors and there was a patient being treated, which raised my suspensions that possibly that clip was included in error. The vast majority of the clips that I viewed did not contain patients and almost all of them included Dr. Dorin as the anesthesiologist. I then came upon a few clips back to back that continued to contain patients. I then decided to cease watching the clips and resolved in my

mind to contact Rick Barton (Sharps Attorney) to discuss if some of these clips were given in error.

7. I did not view the majority of the clips. As to the ones that I did view, I skipped through the majority of those clips. To put things in perspective, Sharp gave me a total of 77 video clips of varying length. Almost all of the ones I viewed had Dr. Dorin in them. Sharp now claims that 14 patients were included in the 77 clips.

8. Thereafter on the same day, Saturday, May 7, 2016, I responded via email to Ms. Clarks questions and informed her that I first indeed did want to talk to any patients that believed they were in those videos and I still do, as I believe those videos will contain further exculpatory evidence for Dr. Dorin's benefit—namely him using drugs he had placed in shirt pocket during the procedures. I secondly informed Ms. Clark that I couldn't answer hear questions as to the exact number of videos, as I discontinued viewing the videos as I had seen clips of patients and believed they were given in error and told her I was going to contact Mr. Barton to determine if they were given in error **(See Exhibit F).**

9. On Monday, May 9th, 2016, before I could clear my schedule to make contact with Mr. Barton, I received a call from him about the issue as Ms. Clark had apparently contacted him directly via email after I emailed her letting her know I was not going to watch all the videos as I believed some of the videos may have been given in error.

10. On the following day, Tuesday, May 10, 2016, I personally delivered the thumb drive back to Mr. Barton's office. I have not watched all the videos that Sharp provided. I did not share the thumb drive with anybody and nobody outside our firm other than my client has ever seen any of these videos.

11. During that time period, I was receiving calls from reporters asking if the patients were visible in the videos during their procedures. These reporters had told me that Sharp was claiming the patients were not visible or identifiable in the videos. Since that was not the case, I decided to take a screen shot of an empty operating room, which I then converted to a pdf file on Sunday, May 8, 2016. This pdf is attached hereto as **Exhibit G**. I also shared this pdf with News

reporters, including Wendy Fry from NBC, as she was specifically requesting that I prove that patients were visible in the background of the video, as she informed me that Sharp had told them there were not. Despite her requests, I declined to share any video with patients and told her the still shot of the empty operating room was all I was willing to share.

12. I showed this picture to Ms. Carder as we discussed that Sharp had told the press that the patients were either not in the view of the camera or not identifiable. In either event, the only photo I had on my phone was that pdf which is attached as Exhibit G.

13. Although I only viewed bits of the video provided, I did find and make notes of several clips that show exculpatory evidence:

- On a clip from April 3rd, 2013 an unidentified male who is NOT Dr. Dorin enters the room and removes a bottle of medication from the top drawer of the anesthesia cart and then immediately leaves the room.
- On another clip from April 3rd, 2013 shows Dr. Dorin entering the room he then empties his front pocket back into the anesthesia cart and leaves with an empty front pocket.
- Also on April 3rd, 2013 an unidentified female was bending down in front of the anesthesia cart—she then stood up abruptly in front of the cart and appears to put something in her left front pants pocket as she leave the room. In that clip, the camera does not show her entering the room and only shows the back of her head as she leaves.
- On March 27th, 2013 a doctor other than Dr. Dorin places something from the anesthesia cart into his front left pocket.
- On April 22nd, 2013 two doctors are seen who are not Dr. Dorin and one of the doctors at the anesthesia carts puts items that appear to be medication into his front pocket on at least two occasions during the video clip.

14. It is clear from the videos viewed that Dr. Dorin and other anesthesiologist regularly use their front upper pocket of their scrubs to put medications, syringes, supplies etc., in and there are multiple instances of them putting drugs in and taking drugs out of their shirt pockets.

15. Attached to the Notice of Lodgment herein are true and correct copies of items as described:

EXHIBIT NO.

A. 10/29/2013 Letter from Sharp to the Medical Board of California

B. 5/16/2016 Open letter to the Public from Dr. Patrick Sullivan which was downloaded by clicking on a link from Exhibit 9 of Respondents NOL

C. 5/19/2016 news article which is A clearer a copy of the same Exhibit 9 filed with Respondents NOL.

D. 7/26/13 Letter from Sharp illustrating Dr. Dorin's fitness to practice.

E. 9/9/2015 copy of the Dr. Dorins report from the National Practitioner Data Bank

F. 11/10/2014 Demand from the Medical Board for Testing of Dr. Dorin

G. 3/21/2013 photo of empty operating room from secret video camera

H. 3/25/2016 Declaration of Carlisle Lewis

I. 5/7/2013-5/9/2013 E-mail string between Cheryl Clark, Duane Admire and Rick Barton

J. 8/1/2008 Union Tribune article relating to death at Sharp Hospital

K. 7/27/2016 Deposition Subpoena for Business Records relating to Dr. Dorin's files which would include the Sharp videos.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true of my personal knowledge, except as to those matters which are therein stated

upon information and belief, and as to those matters, I believe it to be true. Executed at Del Mar, California.

DATED: August 15, 2016

/s/
Duane A. Admire, Esq.
Attorney for Respondent
ADAM F. DORIN, M.D.

PROOF OF SERVICE

Dorin, Adam F.—Office of Administrative Hearings

I am a resident of the State of California, over the age of eighteen years, and not a party to the within action. My business address is: 12880 Carmel Country Road, Ste D110, San Diego, CA 92130. On Augustl 15, 2016 I served the within documents:

Declaration of Duane A. Admire, Esq.

x by transmitting via EMAIL the document(s) listed above to the EMAIL address(s) set forth below on this date before 5:00 p.m.

by placing the document(s) listed above in a sealed envelope with postage thereon fully prepaid, in United States mail in the State of California addressed as set forth below. (witness list and exhibits put in U.S. Mail and sent via email as per agreement)

by personally delivering the document(s) listed above to the person(s) at the address(es) set forth below.

by placing a true copy thereof enclosed in a sealed envelope, at a station designated for collection and processing of envelopes and packages for overnight delivery by Express Mail by U.S. post office as part of the ordinary business practices of Admire & Associates LLP described below, addressed as follows:

Petitioner
Kamala D. Harris, Attorney General of California
Alexandra M. Alvarez, Supervising Deputy Attorney General
Jason Ahn, Deputy Attorney General
600 West Broadway, Suite 1800
San Diego, CA 92101
Tel. (619) 645.2093
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Non-party SHARP
Richard D. Barton (Bar No. 102613)
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PROCOPIO, CORY, HARGREAVES & SAVITCH LLP
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San Diego, CA 92130
Telephone: 858.720.6300
Facsimile: 619.235.0398

I am readily familiar with the firm's practice of collection and processing correspondence for mailing. Under that practice it would be deposited with the U.S. Postal Service on that same

day with postage thereon fully prepaid in the ordinary course of business. I am aware that on motion of the party served, service is presumed invalid if postal cancellation date or postage meter date is more than one day after the date of deposit for mailing in affidavit.

I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

Executed on August 15, 2016, at San Diego, California.

/s/
Duane Admire

EXHIBIT A

SHARP Grossmont Hospital

October 29, 2013

Medical Board of California
Central Complaint Unit
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Re: Adam Dorin, M.D.
Physician License Number: G86440

Dear Medical Board:

Dr. Adam Dorin, a California licensed physician and an anesthesiologist, resigned his membership on the Grossmont Hospital Corporation medical staff on October 15, 2013. Grossmont Hospital believes that although the circumstances of Dr. Dorin's resignation do not require an 805 report to the California Medical Board, the Medical Board should be aware of recent actions and conduct by Dr. Dorin while a member of Grossmont Hospital's medical staff.

On April 9, 2013, Grossmont Hospital's Medical Executive Committee ("MEC") was presented with information concerning Dr. Dorin's apparent removal (on a number of occasions during 2013) of propofol from anesthesia carts located in unoccupied operating rooms. Due to concerns about the potential for substance abuse and the unexplained taking (and use) of the removed propofol, the MEC summarily suspended Dr. Dorin's clinical privileges that day. The MEC met with Dr. Dorin on April 10, 2013. After interviewing Dr. Dorin and receiving other information[1], the MEC determined there was no reasonable likelihood of substance abuse by Dr. Dorin and terminated the summary suspension. At that time the MEC also decided that Medical Staff leadership (the current, former and newly elected Chiefs of Staff) should investigate Dr. Dorin's conduct with regard to the removal of the propofol from the operating room anesthesia carts and the subsequent use of that propofol.

The Medical Staff Leadership conducted its investigation and reported its findings to the MEC on June 11, 2013. At that time the MEC determined to end the investigation and issue Dr. Dorin a formal admonishment (no restriction on clinical privileges or medical

[1] In interviews, Dr. Dorin said it was his practice to have extra vials of propofol and certain other medications available on his person so that he could administer needed medications to patients on an emergent basis if the medications were not immediately otherwise available. He also indicated that he would deposit unused vials of removed medications in anesthesia drug carts at various locations in the hospital. Dr. Dorin said that he did not administer removed drugs to himself and that he did not take the removed drugs from the hospital's premises.

staff membership). Dr. Dorin was informed of the formal admonishment by letter dated June 18, 2013. The conduct by Dr. Dorin that led to the admonishment was:

1. Dr. Dorin's failure to fully explain how medications (specifically propofol) that Dr. Dorin removed from operating room anesthesia drug carts at various times in 2013 were used, relocated or disposed.

2. Dr. Dorin's initial denial that he removed medications (including propofol) from anesthesia drug carts in unoccupied/inactive operating rooms in 2013. Dr. Dorin later admitted removing the propofol after being told that his actions were recorded on video tape.

The Board of Directors of Grossmont Hospital was informed of the MEC's actions with respect to Dr. Dorin in June 2013. At its July 16, 2013, the Board of Directors voted to convene a Joint Conference Committee (composed of members of the Board of Directors and the Medical Staff Leadership) to discuss the MEC's decisions regarding Dr. Dorin. The Joint Conference Committee met several times in August and September 2013.

On September 17, 2013, the Board of Directors voted to request that the MEC consult with the Board of Directors about reconsidering its discipline of Dr. Dorin (the letter of admonishment) and to instead revoke Dr. Dorin's medical staff membership; it being the sense of the Board that Dr. Dorin's conduct described above was potentially detrimental to patient safety and demonstrated a lack of integrity and honesty.

Prior to the MEC consulting with the Board of Directors on the matter and without notice to Dr. Dorin of the Board of Director's consultation request, Dr. Dorin resigned his membership from Grossmont Hospital's medical staff on October 15, 2013.

Dr. Dorin was on Grossmont Hospital's medical staff continuously from November 19, 2002 to October 15, 2013. During that time, Dr. Dorin had not been the subject of any investigations or disciplinary actions prior to the investigation that led to the admonishment described above.

Thank you for considering this information.

Sincerely,

Michele Tarbet

Michele Tarbet
Senior Vice President and
Chief Executive Officer

EXHIBIT B

May 16, 2016

An Open Letter to the Public

My name is Dr. Patrick Sullivan, an anesthesiologist at Sharp Grossmont Hospital from June 19, 1994-Jan 15, 2016. I was Chief of the Anesthesia Department in 2008-2009 and Anesthesia Department representative to the Sharp Grossmont Women's Center and its Ob/Gyn Supervisory Committee for the past 19 years. I served in this capacity, because I spent more of my practice in the Women's Center than any other anesthesiologist and probably spent more time there than any other individual, including administrators and Ob/Gyn physicians. I performed exactly 28,603 anesthetics at Grossmont Hospital, approximately 20,000 of them in the Women's Center. I was privileged and honored that 20,000 or so mainly East County women put their faith and trust in me during my time there, and it was a pleasure to be a part of their lives and of some of the most precious moments of their lives. I got to know their families and developed relationships with many of them that are still ongoing. I have been specially requested to provide anesthesia for other doctors, hospital staff and their families literally hundreds of times. I spent over 2 decades of my life dedicating myself to the Women's Center, introducing improvements, promoting quality of care and patient safety to the best of my ability, volunteering my time attending meetings and troubleshooting and resolving Women's Center issues for the Anesthesia Department. I regularly communicated with the OB Anesthesiology Medical Directors and Chiefs of Anesthesia at Sharp Mary Birch and Sharp Chula Vista to coordinate OB/Gyn Anesthesia policies and procedures. I sat on the selection committee interviewing candidates for the last 3 vacancies in the Sharp Grossmont Women's Center Director position and for 5 vacancies in the L&D Manager position. Because of my extreme investment and involvement in the Women's Center, I can no longer stay silent about what is going on there. In my opinion, Sharp Healthcare and Sharp Grossmont Hospital have severely violated and betrayed the public trust of East County women and the East County community in general.

The story so far has been focused on Dr. Adam Dorin, who has been accused of "stealing anesthesia drugs", mainly based on video clips of him putting drugs in the front pocket of his shirt inside an operating room. While the topics of narcotic abuse and healthcare employees taking drugs are currently riding a wave of national publicity making it easy to assume that anyone accused is guilty, I do not believe he is guilty of a drug diversion in any way whatsoever. I will explain below.

Much more importantly, this diverts attention from the more important story, which is that the videos never should have been taken. In an extreme betrayal of trust, Sharp placed secret, hidden cameras in the WC operating rooms recording thousands of clips that we now know contain images of patients. According to Sharp, "There are 6,966 images contained within the multitude of images of women undergoing operations of a very personal, private nature, unconscious and in states of exposure..." In addition to these videos, there were 6 months more video clips (extrapolating that would be 14,000 more video clips) taken that supposedly "were not retained by Sharp Grossmont Hospital." It is public knowledge that during an Ob/Gyn procedure, women are often put in the lithotomy (also known as the

legs spread apart) position while staff place prep sponges, catheters and instruments inside their genitalia. One can only imagine what might be on these video clips. To add insult to injury, multiple sources reported that the video clips were reviewed by a MALE Sharp security employee. East County women and national women's groups should be fuming mad about this. When I and several of the Ob/Gyn physicians and anesthesiologists discovered the existence of these cameras in March of 2013, we passionately complained to the Women's Center Director and implored her to remove the cameras, but she refused. So instead, anesthesiologists protected patients by putting a piece of tape over the tiny cameras during surgeries until eventually one day they disappeared.

Regarding Dr. Dorin, for the entire duration of Doctor Adam Dorin's ten year tenure as an anesthesiologist with Sharp, let me say unequivocally that he was an exceptionally good and highly valuable anesthesiologist on my team, with no adverse patient care issues of any kind, and never any indication of drug use, theft or diversion. The Women's Center Director had been told repeatedly by me and others that the "missing Propofol" could be explained by the fact that many anesthesiologists were taking Propofol from one area of the hospital to another, because there was a yearlong local and national shortage of Propofol, and Sharp could not procure enough Propofol to put patients to sleep in all areas of the hospital. There were literally times when patients were on the operating table with the surgeon ready and there was no Propofol to put them to sleep. It's that simple. I witnessed many anesthesiologists coming from other operating rooms to get Propofol from the Women's Center ORs because good patient care demanded it, and oftentimes the Women's Center ORs were its only repository in the hospital. Alternative agents to Propofol do exist but have significant side effects. Over the years, I firmly believe that many physicians were seen on film taking meds and supplies, as well as nurses and ancillary staff, for use in a neighboring OR or other patient care area.

In addition, Dr. Dorin was a well known whistleblower, speaking out publicly about patient safety issues. Sharp's refusal (backed up by a judge) to turn over all video clips is a miscarriage of justice. All of the clips need to be turned over. Women who were viewed by the Sharp security employee and/or others have a right to see them in case they are entitled to damages. Dr. Dorin's attorney has a right to see them to clear Dr. Dorin. I find it odd that so many anesthesiologists took drugs out of the Women's Center carts for patient use, but the only video clips Sharp will turn over are the ones showing the whistleblower taking drugs.

East County women and the Grossmont Healthcare District Board should be outraged over this and should demand the following:

1. The immediate resignation of the Women's Center Director, under whose supervision all of this occurred.
2. A subpoena for a 3rd party forensic computer investigator to search all of Sharp's servers (including deleted files) for evidence of the missing 6 months of video clips.
3. An appeal of the court order denying the request that all 6,966 video clips be turned over to Dr. Dorin's attorney. OR the subpoena could be modified to turn the video clips over to a lone female 3rd party agreed to by both attorneys. The tapes should be reviewed for any exculpatory evidence regarding Dr. Dorin.

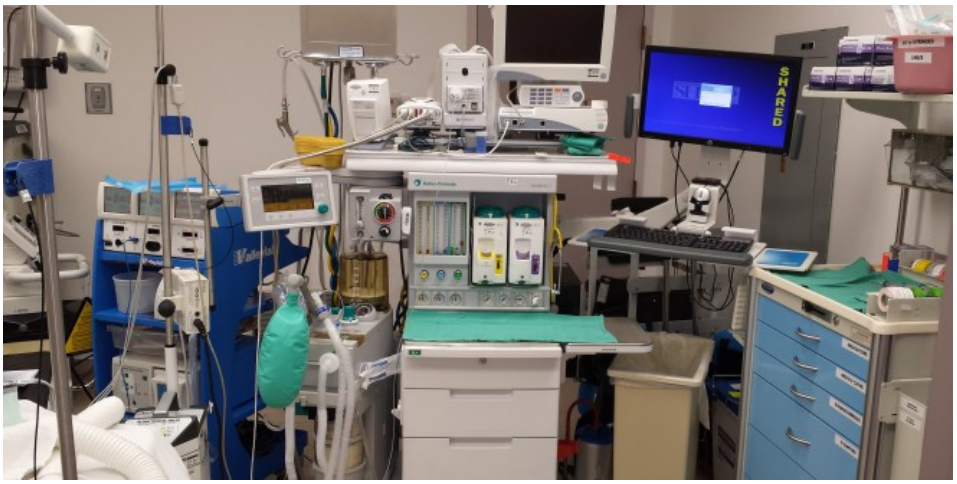
4. An investigation by state and federal agencies.
5. Termination of the lease agreement between Sharp Healthcare and the Grossmont Healthcare District Board based on a breach of section 14.16 which states: "Tenant shall operate the Hospital according to the best interests of the public health of the communities served by the Landlord."
6. A class action lawsuit brought by women of East County who were damaged by this.

Sharp's hypocrisy is astounding. Sharp is concerned about 14 videos they took that were released to an attorney, because of concern that they violated patient privacy. Why aren't they concerned about the other multiple hundreds or thousands of clips that were reviewed by the Sharp security employee? Although well intended, Sharp took way, way too much liberty with this secret videotaping. Many innocent nurses and physicians working in the Women's Center felt that their privacy was violated as well.

Always at your service,

Patrick G. Sullivan, M.D.

EXHIBIT C



Operating room in the Women's Health Center of Sharp Grossmont Hospital during period of video surveillance. Undated. Dr. Adam Dorin

Sharp hospital apologizes for privacy breach as video sting provokes backlash

by **Cheryl Clark** | *May 19, 2016*

Sharp Grossmont Hospital has apologized for releasing 14 video clips that included women undergoing obstetric surgery, an error it said constituted a breach of their medical privacy and has led to state and federal agency notification.

Why This Matters

A major San Diego hospital's yearlong video surveillance of women undergoing surgery to track missing drugs raises

"We are very sorry that this error occurred and that the privacy of these patients was breached," the Sharp Grossmont statement said. The hospital mistakenly released the clips to an attorney representing a doctor the hospital said is seen in the videos taking bottles of sedatives from surgery carts and putting them in his pocket

Hospital spokesman John Cihomsky said Grossmont is trying to identify

questions about hospital operations and security

each patient shown in these clips, and when it does it will notify them of the breach.

Patients, doctors upset

Meanwhile, several women who underwent C-section surgeries to deliver their babies during the course of the hospital's yearlong video surveillance in its Women's Health Center say they are horrified they may be among those captured on video. They believe they never gave consent to be on camera during their most private moments with their doctors, while they were giving birth.

One, Melissa Escalera, 34, said she felt "violated."

Carla Jones, 34, of La Mesa, who delivered her baby by unscheduled C-section, said she is "extremely uncomfortable" knowing her surgery on May 15, 2013, was on video and was viewed by people other than her doctors and nurses.

"If you're missing drugs, you don't just pop cameras in a place where women are naked. It's ridiculous that Sharp thought this was a reasonable way to figure this all out," Jones said.

Two anesthesiologists who worked at the hospital said they also were upset about the video surveillance.

Dr. Patrick G. Sullivan, former chief of the hospital's anesthesia department who no longer works at Grossmont, said in an "Open Letter to the Public" Sharp's operation should prompt "outrage," and that women whose images were captured on videos "are entitled to damages." He said Sharp Grossmont, the second largest in the county with 528 licensed beds, "severely violated and betrayed the public trust of East County women and the East County community in general."

Another Grossmont anesthesiologist, Dr. David R. Diehl, told a medical executive committee on April 10, 2013, that the removal of drugs probably wasn't theft. "Anesthesia carts are unlocked and physicians often take 1-3 vials for emergencies; these are life and death situations," according to minutes from that meeting.

Sharp Grossmont launched its surveillance operation with hidden cameras in three operating rooms at its Women's Health Center on July 17, 2012, to determine why drugs, including the sedative propofol, were missing, Sharp documents say. Seven months later, in February 2013, the videos began to show that an anesthesiologist, Dr. Adam Dorin, was putting bottles of the drugs in his pocket, Sharp documents say. *inewsource* first reported about the video operation May 5.

The surveillance continued through June 2013, capturing Dorin taking a total of 12 bottles of medications, Sharp documents allege.

Nevertheless, Dorin, 52, continued to provide anesthesia services at the hospital until mid-October, when he resigned. The fact that he was allowed to continue working at the hospital raises questions about why, if hospital leadership believed he was taking, abusing or selling drugs for personal gain, it didn't act more aggressively to remove him from the staff. It did not relay its concerns or file

documents about its investigation with the Medical Board of California until after Dorin left in October for a new job in Palmdale.

"Why didn't they send Dorin to the (Medical Board of California) immediately?" asked Duane Admire, an attorney who represents Dorin.

Sharp has not answered that question.

Admire said he has had numerous conversations with other doctors and nurses in the hospital who are angry that it conducted surveillance on them without their knowledge. It compromised physicians' relationships with their patients, he said.

Propofol in short supply

In April 2013, the hospital's medical executive committee, an independent peer review organization that grants physician staff privileges, suspended Dorin but lifted the suspension the next day after learning that propofol was in short supply, and that many anesthesiologists grabbed it to prepare for emergencies. That was confirmed by Sullivan.

Those drugs were missing because, Sullivan wrote, "there was a year-long local and national shortage of propofol, and Sharp could not procure enough propofol to put patients to sleep in all areas of the hospital." So anesthesiologists would take the drug from one area to another.

"There were literally times when patients were on the operating table with the surgeon ready, and there was no propofol to put them to sleep," he wrote.

Admire wants to privately review the 14,000 or so video clips taken during the surveillance, saying they will exonerate Dorin by showing many doctors taking drugs just like Dorin did. They also will show Dorin replacing some of the drugs in other carts or using them on patients, Admire said.

Sharp has refused. It said releasing those videos would compromise patient privacy because they show women "exposed," "under anesthesia," and "in their most vulnerable state."

"Sharp Healthcare and Sharp Grossmont Hospital have severely violated and betrayed the public trust of East County women and the East County Community in general." – Dr. Patrick G. Sullivan, former Grossmont chief of anesthesiology.

A self-described whistle-blower

Dorin and another doctor who still practices at Sharp Grossmont believe Dorin was targeted for discipline.

Dorin has acknowledged he has been a frequent whistle-blower, and often complained about safety issues at Sharp Grossmont. In 2008, he told the county medical examiner and a reporter for The San Diego Union-Tribune about a hospital error he said resulted in a patient's death. The case resulted in a family lawsuit against the hospital.

In a phone interview Tuesday, Diehl said he attended that medical executive

committee meeting on April 10 because he had learned that "they had set up these cameras, which I was quite upset about because they were like spying."

Diehl said the story "is not about drug diversion (medical personnel taking medications intended for patients for personal use or gain). The real story was that Michele Tarbet (Grossmont's former senior vice president and CEO , who is now deceased) had a vendetta against Dorin. When she found out he was taking the drugs, she used that against him to get rid of him. ... She went to great lengths to do that."

Diehl emphasized that he did not know exactly why Tarbet wanted Dorin off the staff.

In June 2013 the medical executive committee formally admonished Dorin because when he was first asked about the drugs, he denied taking them, and was thought to have lied about it. Admire said Dorin countered that he thought he was being asked if he took drugs outside the hospital, which he had not. The committee stopped far short of curtailing his ability to practice on staff.

Two weeks after Dorin left Sharp, Tarbet sent a letter to the Medical Board of California detailing Dorin's brief suspension and subsequent admonishment. "Dr. Dorin's conduct described above was potentially detrimental to patient safety and demonstrated a lack of integrity and honesty," she wrote.

That got the Medical Board of California's attention and it launched its own investigation. In January 2014, Sharp sent the medical board a thumb drive containing 12 video clips that the hospital said documented Dorin putting the drugs in his pocket.

77 video clips

Last September, the medical board filed a formal accusation against Dorin, who subsequently hired Admire for his defense.

In reviewing evidence against Dorin, Admire noticed the thumb drive contained multiple clips with "extremely graphic" views of identifiable women undergoing vaginal or abdominal surgery, exactly what Sharp officials said they had not released.

"Of the first four patients that I happened to view before I quit and decided to figure out how best to deal with the problem, (I) discovered that two of the women patients were not under anesthesia — as one of them walked into the operating room, another you can clearly see was adjusting herself and her hair cap etc., and the other two, did seem to be under anesthesia," Admire said in an e-mail.

In all, Admire said the thumb drive he received from the hospital included about 77 video clips He said he watched about 12 and saw "at least five to six different women having procedures." Some of the clips may show more than one patient, so it is unclear how many separate patients are visible.

On May 16, hospital spokesman Cihomsky said in an e-mail that the hospital had reported the breach to the California Department of Public Health and will report the breach to the federal Department of Health and Human Services Office for

Civil Rights. He said in his statement: "Our intention was to send the attorney only the same video clips that were sent to the California Medical Board in January 2014 that contained no video of patients."

Hospital might be fined

The California Department of Public Health said on Wednesday that it "is aware of the alleged incident(s)" and is investigating whether the Sharp Grossmont Hospital privacy breach constitutes a violation of the Health Insurance Portability and Accountability Act (HIPAA).

Under state law, the hospital could be penalized up to $25,000 per patient whose medical information was breached, and up to $17,500 per subsequent breach of that patient's medical information, with a cap of $250,000.

It said the U.S. Department of Health and Human Services also enforces HIPAA violations.

Questions remain about whether the hospital had the right to conduct widespread video surveillance of women undergoing surgery.

Cihomsky insisted the hospital did, because all patients sign the hospital's Admission Agreement consent form before receiving services. The agreement reads:

"You consent to all hospital services rendered under the general and special instructions of your physician(s), and to the taking of photographs and videos of you for medical treatment, scientific, education, quality improvement, safety, identification or research purposes, at the discretion of the hospital and your caregivers and as permitted by law."

However, that consent form, Cihomsky said, does not give the hospital permission to release protected health information to outsiders. "We have a separate obligation to keep protected health information confidential," he wrote in an e-mail. "We should not have shared the information with Mr. Admire."

Julianne D'Angelo Fellmeth, administrative director for the Center for Public Interest Law and the enforcement monitor for the Medical Board of California, said in an email she's "not sure if a patient can waive HIPAA and/or other rights via a blanket paragraph contained in an adhesive contract that a patient is likely forced to sign in order to receive treatment."

"Most of the time, patients are not able to opt out of any of those paragraphs; plus the signature may be under duress due to the patient's need for hospitalization," Fellmeth wrote.

Melissa Escalera of Lemon Grove, who delivered her baby by emergency C-section on Sept. 4, 2012, said she was horrified at the idea her surgery was captured on video and is contemplating legal action.

"I feel violated, like my privacy and confidentiality were compromised, and that's not the feeling you want to have when you go to a hospital to give birth," Escalera said.

Dorin believes Sharp Grossmont is retaliating against him for being a whistle-blower in 2008 and complaining about other issues at the hospital.

He denies he used or stole drugs from the hospital, or used them for anything other than patients under his care.

About Cheryl Clark:

Cheryl Clark is a senior healthcare reporter at inewsource. To contact her with questions, tips or corrections, email cherylclark@inewsource.org.

Previous:
Early Voting in San Diego's June 7, 2016 Primary Election: Updated Daily

Next:
Newsletter: Sharp hospital apologizes for privacy breach as video sting provokes backlash

inewsource
5500 Campanile Drive | PSFA 361C
San Diego, CA 92182
(619) 594-5100

San Diego's source for independent, nonpartisan investigative journalism.
Investigative Newsource, d.b.a. inewsource, Federal Tax ID #27-0732786, is a registered 501(c)(3) public charity. All or part of your gift may be tax deductible as a charitable contribution. Please check with your tax advisor.

EXHIBIT D

SHARP® Grossmont Hospital

July 26, 2013

To Whom It May Concern:

Sharp Grossmont Hospital has received your request and release for information on the practitioner listed below. Due to the volume of inquiries with respect to current and former staff members, a form-type reply has been generated.

Only the following information will be provided:

Name:	Adam Dorin, MD
Staff Status:	Active
Specialty:	Anesthesiology
Appointment Date:	11/19/2002 to Present

There are no quality concerns regarding Dr. Dorin's patient care.

If you have further questions or concerns, please do not hesitate to contact the Medical Staff Office.

Sincerely,

Lesley Bradley

Lesley Bradley
Manager, Medical Staff Services

DISCLAIMER AND CONFIDENTIALITY NOTICE

Due to the high volume of request for information, this service is provided only as a convenience to expedite the credentialing process. By accessing https://www.verify.sharp.com/iResponse/ApplicationSpecific/Registration/login.asp, you acknowledge the information provided by this service is confidential and that you have proper release from the physician to obtain such information.

If you cannot locate a physician or if you have any questions, please contact Medical Staff Services.

EXHIBIT E

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

5500000099757632
Process Date: 09/09/2015

To: DORIN, ADAM FREDERIC

3972 BARRANCA PKWY
J115
IRVINE, CA 92606-1204

From:

Re: National Practitioner Data Bank
Response to Your Self-Query

The enclosed information is released by the National Practitioner Data Bank (NPDB) for restricted use under the provisions of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986, as amended; Section 1921 of the Social Security Act; and Section 1128E of the Social Security Act.

Title IV established the NPDB as an information clearinghouse to collect and release certain information related to malpractice payment history and professional competence or conduct of physicians, dentists, and other licensed health care practitioners.

Section 1921 of the Social Security Act expanded the scope of the NPDB. Section 1921 was enacted to protect program beneficiaries from unfit health care practitioners, and to improve the anti-fraud provisions of federal and state health care programs. Section 1921 authorizes the NPDB to collect certain adverse actions taken by state licensing and certification authorities, peer review organizations, and private accreditation organizations, as well as final adverse actions taken by state law or fraud enforcement agencies (including, but not limited to, state law enforcement agencies, state Medicaid Fraud Control Units, and state agencies administering or supervising the administration of a state health care program), against health care practitioners, health care entities, providers and suppliers.

Section 1128E of the Social Security Act was added by Section 221(a) of Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996. The statute established a national data collection program (formerly known as the Healthcare Integrity and Protection Data Bank) to combat fraud and abuse in health care delivery and to improve the quality of patient care. Section 1128E information is now collected and disclosed by the NPDB as a result of amendments made by Section 6403 of the Affordable Care Act of 2010, Public Law 111-148. Section 1128E information includes certain final adverse actions taken by federal agencies and health plans against health care practitioners, providers, and suppliers.

Regulations governing the NPDB are codified at 45 CFR part 60. Responsibility for operating the NPDB resides with the Secretary of the U.S. Department of Health and Human Services (HHS), and HRSA, Division of Practitioner Data Banks.

Reports from the NPDB contain limited summary information and should be used in conjunction with information from other sources in granting privileges, or in making employment, affiliation, contracting or licensure decisions. NPDB responses may contain more than one report on a particular incident, if two or more actions were taken as a result of a single incident (e.g., an exclusion from a federal or state health care program and an adverse licensure action). The NPDB is a flagging system, and a report may be included for a variety of reasons that do not necessarily reflect adversely on the professional competence or conduct of the subject named in the report.

All information received from the NPDB is considered confidential and must be used solely for the purpose for which it was disclosed. Further, ANY PERSON WHO VIOLATES THE CONFIDENTIALITY PROVISIONS AS SPECIFIED IN TITLE IV OF PUBLIC LAW 99-660, AS AMENDED, IS SUBJECT TO A CIVIL MONEY PENALTY OF UP TO $11,000 FOR EACH VIOLATION. Subjects of reports who obtain information about themselves from the NPDB are permitted to share that information with anyone they choose.

If you require additional assistance, visit the NPDB web site (http://www.npdb.hrsa.gov) or contact the NPDB Customer Service Center at 1-800-767-6732 (TDD: 1-703-802-9395). Information Specialists are available to speak with you weekdays from 8:30 a.m. to 6:00 p.m. (5:30 p.m. on Fridays) Eastern Time. The NPDB Customer Service Center is closed on all Federal holidays.

NATIONAL PRACTITIONER DATA BANK
NPDB
P.O. Box 10832
Chantilly, VA 20153-0832

http://www.npdb.hrsa.gov

DORIN, ADAM FREDERIC - SELF-QUERY RESPONSE

A. SUBJECT IDENTIFICATION INFORMATION (Recipients should verify that subject identified is, in fact, the subject of interest.)

Practitioner Name: DORIN, ADAM FREDERIC
Date of Birth: 06/10/1963 **Gender:** MALE
Organization Name: ADAM DORIN, M.D., MBA
Work Address: 3972 BARRANCA PKWY, J115, IRVINE, CA 92606-1204
Social Security Number: ***-**-2639 **DEA:** BD2507018
NPI: 1396760427
License: PHYSICIAN (MD), G86440, CA, ANESTHESIOLOGY
Professional School(s): UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE (1989)

B. PAYMENT INFORMATION

Credit Card Information: XXXXXXXXXXXX2746 (08/2019)
NPDB Charge: $5.00* **NPDB Bill Reference Number:** N38234020
* Each charge will appear separately on your credit card statement.
Transaction Date: 09/09/2015 **Additional Paper Copies Requested:** 0

C. SUMMARY OF REPORTS ON FILE WITH THE DATA BANK AS OF 09/09/2015

The following report types have been searched:

Medical Malpractice Payment Report(s):	No Reports	Health Plan Action(s):	No Reports
State Licensure Action(s):	No Reports	Professional Society Action(s):	No Reports
Exclusion or Debarment Action(s):	No Reports	DEA/Federal Licensure Action(s):	No Reports
Government Administrative Action(s):	No Reports	Judgment or Conviction Report(s):	No Reports
Clinical Privileges Action(s):	No Reports	Peer Review Organization Action(s):	No Reports

Copies of these reports are enclosed for restricted/limited use as prescribed by statutes listed on the preceeding cover page.

---------- No Reports Found ----------

EXHIBIT F

RE: speaking with the press

Barton, Richard D.

Mon 5/9/2016 5:16 PM

To:'Duane Admire' <duaneadmire@outlook.com>;

Cc:Carder, Shelley A. <Shelley.Carder@procopio.com>; Mueller, Natalie N. <natalie.mueller@procopio.com>;

Duane- First, I apologize for any profanity. It reflected the anger that Sharp would have accusations like this made before you ever clarified the relevant issue, i.e., whether patients consented to having photographs and videos taken while at Sharp. Second, you are totally confused about the statements made in our papers filed in support of the motion to quash. Our argument to the OAH was that *dissemination of the photos or videos to you* would violate employees and patients' rights. The court agreed with this in its rulings on both the original motion and in your motion for reconsideration.
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Please return to our office the flash drive and anything else you received responsive to the content of the videos. Please do not make copies and please do not disseminate any information or images to anyone. We will clarify whether the information you received is the same as what was provided to the Medical Board. We will also provide you with a response that is exactly what we provided to the Medical Board and is consistent with the now, multiple rulings from the OAH. Rick

RICHARD D. BARTON
PARTNER
PROCOPIO

P. 619.515.3299 | rick.barton@procopio.com
525 B STREET, SUITE 2200, SAN DIEGO, CA 92101
[www.procopio.com]View Profile | Linkedin | procopio.com

From: Duane Admire [mailto:duaneadmire@outlook.com]
Sent: Monday, May 09, 2016 3:40 PM
To: Barton, Richard D.
Subject: Re: speaking with the press

Rick:

Sorry we ended up yelling at each other over the phone. However, if you have any ability to either show me a consent for such secret video or some type of law that doesn't require a patients consent, I will let anybody with the media knows that calls me. Simply yelling that I don't know what the Fuck I'm talking about just pisses me off and makes me want to call the press directly! Thanks, Duane

From: Duane Admire <duaneadmire@outlook.com>
Sent: Monday, May 9, 2016 3:13 PM
To: rick.barton@procopio.com
Subject: email to Cheryl

> On May 7, 2016, at 9:23 PM, Duane Admire <duaneadmire@outlook.com> wrote:
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> Cheryl:
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> First, I also would like to talk to any patients that believe they were in any of those operating rooms during the timeframe, please send them my number and ask them to please call me.
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EXHIBIT G


Thursday, March 21, 2013, at 03:49:33 PM

EXHIBIT H

Richard D. Barton (Bar No. 102613)
E-mail:rick.barton@procopio.com
Shelley A. Carder (Bar No. Bar No.: 137755)
E-mail:shelley.carder@procopio.com
PROCOPIO, CORY, HARGREAVES & SAVITCH LLP
12544 High Bluff Drive, Suite 300
San Diego, CA 92130
Telephone: 858.720.6300
Facsimile: 619.235.0398

Attorneys for non-party SHARP GROSSMONT HOSPITAL

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

In the Matter of the Accusation Against ADAM F. DORIN, M.D. Physician's & Surgeon's Certificate No. G86440, Respondent.	Case No. 800-2013-000930 OAH NO.: 2015120747 DECLARATION OF CARLISLE LEWIS, III IN SUPPORT OF MOTION TO QUASH AND/OR FOR PROTECTIVE ORDER [GOV. CODE §§11507.5 AND 11507.6; CIVIL CODE § 56 ET SEQ.; CODE OF CIVIL PROCEDURE §§2031.060 AND 2017.020(A); 45 C.F.R. §165.512;.§1026] Hearing Date: Oct. 17-21, 2016

1. I, Carlisle ("Ky") C. Lewis, III, am the Senior Vice President and General Counsel of Sharp HealthCare. I have personal knowledge of the matters set forth herein, except as to those matters stated on information and belief and, as to those matters, I believe them to be true. If called as a witness, I would competently testify to the same.

2. Sharp Grossmont Hospital ("SGH") is one of the hospitals within the Sharp HealthCare system. In or about May of 2012, SGH received a report that drugs were disappearing from anesthesia cards in the three Women's Health Center Operating Rooms. Accordingly, SGH's security undertook a number of steps to investigate the matter. On or about July 17, 2012, SGH installed video cameras on the drug carts in the three operating rooms. Filming began thereafter

and continued through June of 2013. Motion-detecting cameras were installed on the top of the drug carts in the three operating rooms and would capture images whenever someone entered the \room.

3. As would be expected with the multiple operating rooms and the lengthy period of time during which this investigation was conducted, the video clips depict numerous persons coming in and out of these operating rooms over eight months. Some of the video clips depict patients in their most vulnerable state, under anesthesia, exposed and undergoing medical procedures. The video clips also depict healthcare providers other than Dr. DORIN working in an area that is not open and/or accessible to the public. The video clips even capture images of other persons who had reason to come and go through the operating rooms, such as administrators, maintenance staff, vendors, etc.

4. SGH security reviewed the video clips that were captured and found multiple occasions between September 14, 2012 through April 3, 2013 in which Dr. DORIN is observed on camera, entering one or more of the operating rooms and removing items from the drug carts including propofol, and placing the items into his shirt pocket. Three clips captured on April 3, 2013 evidence a suspicious sequence of events. The first clip at 2:20 p.m. evidences the staff stocking the cart with medications. The second clip at 2:23 p.m. evidences Dr. DORIN entering an otherwise empty operating theater, taking drugs from the cart and putting them in his shirt. The third clip of video evidences the staff re-entering the room to count the medications on the cart to confirm that, indeed, propofol was now missing from the cart.

5. In order to present SGH's findings to its Board, I directed that twelve clips of video be collected together, the three clips previously mentioned from April 3, 2013, and the following additional video clips: 2:18 a.m. on April 3, 2013; 11:34 p.m. on April 2, 2013; 2:04 p.m. on March 27, 2013; 5:02 a.m. on March 19, 2013; 9:37 p.m. on February 6, 2013; 12:27 a.m. on January 8, 2013; 2:45 a.m. on January 4, 2013; 12:11 a.m. on December 11, 2012 and 12:34 a.m. on September 14, 2012. All twelve of these video clips were collected, copied and provided to SGH's executive committee, the joint committee of the Board of Directors and the Medical Executive Committee, the Board of Directors. The purpose of this action was to support the investigatory

action commenced against Dr. DORIN. The same collection of video clips was also produced to Dr. DORIN and the Attorney General/Medical Board of California.

6. The remaining video clips capturing images between July 2012 and February of 2013 were not retained by SGH. However there are 6,966 video clips capturing images between February 1, 2013 and June 25 of 2013. Expect for the video clips identified above, none of the other 6,966 video clips were utilized in connection with any investigations involving Dr. DORIN at SGH. None of the other 6,966 video clips were produced to the Attorney General/Medical Board of California. None of the other 6,966 video clips provide any exculpatory evidence for Dr. DORIN. For example, there are no clips contemporaneous to the produced clips which depict him returning medication to the carts. In fact, thee depictions on these other video clips are completely irrelevant to the question of whether Dr. DORIN acted in the manner alleged.

7. On or about October 9, 2015, I was served as the representative of Sharp HealthCare and SGH with an administrative subpoena requesting certain records in connection with the matter pending against ADAM F. DORIN, M.D. filed by the Medical Board Of California, Accusation No. 800-2013-000930. A true and correct copy of the subpoena is filed as Exhibit A in support of this motion. In my capacity as Senior Vice President and General Counsel of Sharp HealthCare, I reviewed the subpoena. Although it is my understanding and belief that Sharp HealthCare and/or SGH was not required to comply with this subpoena, I directed that the same documents which had been provided to the Medical Board also be provided to counsel for Dr. DORIN.

8. By letter dated November 11, 2015, on behalf of Sharp HealthCare and SGH, I responded to counsel for Dr. DORIN and objected to the request to produce "all video from all video cameras installed in the Sharp Grossmont Hospital Women's Health Center Operating Rooms between July 17, 2012 through April 3, 2013." In my correspondence I also raised Sharp HealthCare and SGH's objection to the requested production of documents covered by the attorney/client privilege, attorney work product privilege, as well as documents containing protected health information. A true and correct copy of my correspondence responding to the subpoena is filed as Exhibit B in support of this motion.

/ / /

9. I sought to assure Dr. DORIN that Sharp had "produced the video relating to Dr. Dorin that was presented to Sharp Grossmont Hospital's executive committee, the joint committee of the Board of Directors and the Medical Executive Committee, as well as the Board of Directors." There were no video clips used in the administrative proceedings that were not produced to the parties in this proceeding.

10. In addition, on behalf of Sharp HealthCare and SGH, I declined to ". . . produce all the video that was retained during the investigation as it may contain protected health information and was not part of the information presented to the Medical Executive Committee, the joint committee or the Board of Directors."

11. It is Sharp HealthCare and SGH's position that the request for the entire nine months of video runs afoul of privacy interests of a multitude of persons, protected by among other things by Article 1, Section 1 of the California Constitution, the California Medical Information Act (Civil Code § 56 *et seq*., and specifically §56.10), California Evidence Code § 994, the Fourth and/or Ninth Amendments to the U.S. Constitution and/or the Health Insurance Portability and Accountability Act (HIPAA). It is Sharp HealthCare and SGH's position that disclosure of these additional 6,966 video clips are irrelevant, unlikely to lead to any relevant or exculpatory evidence.

12. Disclosure of the additional video clips would be an unreasonable intrusion into the privacy rights of many other persons and create a significant burden on SGH. The question of whether or not the video clips already in the possession of the parties accurately and clearly evidences the conduct alleged is not enhanced by any further production. The remaining 6,966 video clips are irrelevant to the allegations in the Accusation. To require production would be unduly burdensome and invade significant rights of privacy of numerous persons who have a right to the continued protection of their personal identifiable health information and their general rights of privacy.

13. The 6,966 video clips all capture scenes within the three operating rooms, which are not open to the public. There are images contained within the multitude of images of women undergoing operations of a very personal, private nature, unconscious and in states of exposure

/ / /

depending on the operation being performed. In addition, there are depictions of staff and other persons who also have rights of privacy which should be respected.

14. Code of Civil Procedure section 1985.3 requires notification of third parties whose personal privacy will be infringed by compliance with subpoenas. Given the number of persons who appear in the 6,966 video clips, this would require numerous hours to identify, find, and notify such persons and it may not even be possible to accomplish this given the voluminous number of video clips. Furthermore, the task of providing the identities of the persons who require notification would also violate privacy interests of those persons and the law or require Sharp Healthcare and/or SGH undertake the significant burden of attempting to accomplish this task. Sharp HealthCare and SGH contends such action is unwarranted. The intangible benefit Dr. DORIN hopes to obtain by production of the remaining video is far outweighed by the burden he seeks to place on Sharp HealthCare and SGH. Given the fact that his unprofessional and inappropriate conduct already necessitated time, expense and burden on Sharp HealthCare and SGH to conduct the investigation, it is unreasonable to place additional burden on Sharp HealthCare and SGH.

15. If this Court were to order production of all the 6,966 video clips and seek to protect the images of patients and third parties, it would require the expertise of an outside vendor to de-identify the depictions of persons captured on these thousands of video images. I cannot even estimate how expensive this would be or how long this would take. This would create an unreasonable burden which is incommensurate with any possible benefit that could be derived by Dr. DORIN.

16. After receipt of my response, counsel for Dr. DORIN and I have had several conversations regarding the videos. I have explained the concern that it would invade the most crucial privacy rights of Sharp HealthCare and SGH's patients, often in their most vulnerable state, under anesthesia and exposed on the operating room table. In addition, production of the remainder of the video would invade the privacy rights of Sharp HealthCare and SGH's other physicians and health care providers, employees, and other persons. I have sought to assure Dr. DORIN there is nothing on these videos that is relevant to the issues raised in the Accusation. It is

my opinion Dr. DORIN has not, and indeed cannot, establish the compelling interest required to violate these significant rights of privacy of a multitude of persons.

17. Since Sharp HealthCare and SGH's response to the administrative subpoena through my letter of November 11, 2015, Dr. DORIN has raised no other objection to Sharp HealthCare and SGH's response except the continued demand for the entirety of video captured and retained by Sharp HealthCare and SGH. However, despite our meet and confer efforts, Dr. DORIN continues to assert a right to the entirety of video requested in the subpoena and Sharp HealthCare and SGH continues to assert he is entitled to no such thing. Although counsel for Dr. DORIN and I have met and conferred on the issue on several occasions, we have reached an impasse, necessitating this motion.

18. As documented in e-mails dated December 23, 2015 and March 9, 2016, counsel for Dr. DORIN agreed to waive any time requirement regarding the filing of this motion, as we agree a judge should rule on the merits of this motion. A true and correct copy of these emails are collectively filed as Exhibit C.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct and that this declaration was executed on this 25th day of March, 2016, at San Diego, California

By: _____
Carlisle ("Ky") C. Lewis, III
Senior Vice President and General Counsel,
Sharp HealthCare

EXHIBIT I

RE: speaking with the press

Barton, Richard D.

Mon 5/9/2016 5:16 PM

To:'Duane Admire' <duaneadmire@outlook.com>;

Cc:Carder, Shelley A. <Shelley.Carder@procopio.com>; Mueller, Natalie N. <natalie.mueller@procopio.com>;

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RICHARD D. BARTON
PARTNER
PROCOPIO

P. 619.515.3299 | rick.barton@procopio.com
525 B STREET, SUITE 2200, SAN DIEGO, CA 92101
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EXHIBIT J

UT

Questions are raised on death at hospital

2 inquiries launched over care of patient at Sharp Grossmont

By Cheryl Clark
STAFF WRITER

August 1, 2008

State health regulators and the county medical examiner are separately investigating whether a finance author died July 25 because of a lapse in care at Sharp Grossmont Hospital, which already is under scrutiny for three preventable deaths since March.

The previous deaths and other serious patient care and management problems could prompt the government to stop all federal payments to the La Mesa hospital.

Harvey Ira Houtkin, 59, who was dubbed "the father of day trading," died at 9:25 p.m. – several hours after uneventful emergency surgery near his tonsils, according to his medical records. The cause of death was listed as natural: acute respiratory failure from a severe airway obstruction.

The medical examiner, Dr. Glenn Wagner, declined to do an autopsy because hospital officials linked the death to Houtkin's medical history, which included diabetes and a tonsillar abscess. Houtkin's body was flown to Florida, where he lived.

But on Wednesday, Wagner revisited the case after a Sharp Grossmont physician anonymously sent an e-mail to him alleging that the surgeon who signed Houtkin's death certificate gave "erroneous, misleading and perhaps fraudulent" information.

The doctor also sent e-mails and spoke with *The San Diego Union-Tribune* on the condition that he not be identified because of his working relationships with Sharp Grossmont officials. The newspaper verified that he has staff privileges at the hospital.

Overview

Background: Sharp Grossmont Hospital in La Mesa could lose all federal payments because of serious lapses in patient care and management, including the preventable deaths of three patients in March and April.

What's changing: State regulators and the county medical examiner are investigating whether a fourth preventable death occurred July 25.

The future: State and federal officials are reviewing the hospital's correction plans and will soon reinspect the facility.

The physician said Houtkin actually died because of a problematic adjustment or dislodging of his breathing tube, which then blocked his airway while he was waiting for a bed in the intensive care unit, or ICU.

No staff member had noticed quickly enough that Houtkin had turned blue, the doctor said, and efforts to save him came too late.

"What ensued was a very messy scene where the anesthesiologists could not reintubate the patient and the surgeon could not establish" an opening in the windpipe, the physician said.

Houtkin's death is "an indictment – albeit at an unfortunate time politically for the hospital – on the nursing and respiratory care at Sharp Grossmont," the doctor said.

Grossmont," the doctor said.

Sharp Grossmont's leaders denied that events unfolded that way.

"The patient was very ill" with other health issues, said Dan Gross, executive vice president of Sharp HealthCare.

"The patient did have complications post-surgery in ICU, coded and expired," he said. "There is no evidence at this time the tube was dislodged and definitely no information regarding lack of observation."

Gross said the hospital was not required to report the event to the state, but did so because of the ongoing investigations by state and federal regulators.

"I honestly believe this message is coming from an individual who has a history of conflict with our management, a man who has intent to harm Sharp Grossmont publicly," he said.

Last night, hospital officials said an autopsy would help determine why Houtkin went into cardiopulmonary arrest and died.

Sharp's administrators acknowledged that they're under the gun. Federal and state regulators are reviewing their correction plans and will reinspect the hospital before Oct. 15.

If deficiencies remain, the facility would lose all Medicare and Medi-Cal reimbursement, which make up 50 percent of its net patient revenue. The government programs cover treatment for seniors, the poor and the disabled.

During two inspections of the hospital in April and May, state investigators found problems such as nurses poorly trained in cardiopulmonary resuscitation, improper use of restraints for psychiatric patients, an old operating-room mattress held together by tape and glue, outdated medications, wrong food storage and inadequate cleaning of kitchen equipment.

At the top of their list were three preventable deaths:

- Larry Napolis, 45, a heart-attack patient who died March 21 because his ventilator was left off.
- Jeffrey Christopher, 25, a patient in the psychiatric unit who died April 11 after suffocating on his mattress because of improper restraints and monitoring by staff.
- Mary Ruth Keimig, 83, who died April 24 after a hysterectomy because the hospital's staff injected a powerful drug into her bloodstream instead of into her muscle.

The inspectors attributed those deaths, and dozens of other serious issues, to deficiencies in hospital procedures, training and operations.

In the Houtkin case, the state said yesterday it is investigating the death.

Houtkin had come to the Optimum Health Institute in Lemon Grove for a three-week stay to lose weight, his son and daughter-in-law, Michael and Jamie Houtkin, said in an interview from Florida.

On July 25, Houtkin went to an urgent-care clinic after two days of worsening throat pain. He was diagnosed with an abscess near his tonsils, according to his medical records. Houtkin was driven by car to Sharp Grossmont Hospital, where he underwent surgery.

By state law, hospital officials must report "sudden" or "unexpected" deaths to the county Medical Examiner's Office, which performs autopsies and pathology testing to determine how those deaths occurred.

Houtkin's family said it had ordered an autopsy because of concerns about how the patient died.

The doctor who sent e-mails to Wagner and the *Union-Tribune* said, "Medical record-keeping was purposefully 'watered down' to avoid

stating what actually happened and to avoid a formal inquiry and autopsy."

Wagner subpoenaed Houtkin's medical records Wednesday night and received them yesterday morning. He said he found "crucial information" not included in those documents, "including minute by minute patient monitoring data in the recovery room during which time Mr. Houtkin" went into cardiac arrest.

With all of the new information, Wagner said, "I would likely have brought the case in for autopsy."

He said Houtkin's death could be changed from natural to accidental "depending on what we find in our investigation, as well as any provided findings by the family-requested autopsy in Florida."

»Next Story»

EXHIBIT K

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:
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ATTORNEY FOR *(Name)*: Plaintiff Melissa Escalera

FOR COURT USE ONLY

SUPERIOR COURT OF CALIFORNIA, COUNTY OF SAN DIEGO
STREET ADDRESS: 220 West Broadway
MAILING ADDRESS:
CITY AND ZIP CODE: San Diego, CA 92101
BRANCH NAME: Central

PLAINTIFF/PETITIONER: Melissa Escalera
DEFENDANT/RESPONDENT: Sharp Healthcare, et. al.

DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

CASE NUMBER:
37-2016-00017392

THE PEOPLE OF THE STATE OF CALIFORNIA, TO *(name, address, and telephone number of deponent, if known)*:
Admire & Associates,12880 Carmel Country Rd,Suite D110, San Diego, Ca 92130; (858) 350-5565

1. **YOU ARE ORDERED TO PRODUCE THE BUSINESS RECORDS described in item 3, as follows:**

To *(name of deposition officer)*: Patterson Law Group
On *(date)*: August 16, 2016 At *(time)*: 10:00 am
Location *(address)*: 402 West Broadway, 29th Floor, San Diego, CA 92101

Do not release the requested records to the deposition officer prior to the date and time stated above.

a. ☑ by delivering a true, legible, and durable **copy** of the business records described in item 3, enclosed in a sealed inner wrapper with the title and number of the action, name of witness, and date of subpoena clearly written on it. The inner wrapper shall then be enclosed in an outer envelope or wrapper, sealed, and mailed to the deposition officer at the address in item 1.

b. ☐ by delivering a true, legible, and durable **copy** of the business records described in item 3 to the deposition officer at the witness's address, on receipt of payment in cash or by check of the reasonable costs of preparing the copy, as determined under Evidence Code section 1563(b).

c. ☐ by making the **original** business records described in item 3 available for inspection at your business address by the attorney's representative and permitting **copying** at your business address under reasonable conditions during normal business hours.

2. *The records are to be produced by the date and time shown in item 1 (but not sooner than 20 days after the issuance of the deposition subpoena, or 15 days after service, whichever date is later). Reasonable costs of locating records, making them available or copying them, and postage, if any, are recoverable as set forth in Evidence Code section 1563(b). The records shall be accompanied by an affidavit of the custodian or other qualified witness pursuant to Evidence Code section 1561.*

3. The records to be produced are described as follows *(if electronically stored information is demanded, the form or forms in which each type of information is to be produced may be specified)*:
Please see Attachment 3

☐ Continued on Attachment 3.

4. **IF YOU HAVE BEEN SERVED WITH THIS SUBPOENA AS A CUSTODIAN OF CONSUMER OR EMPLOYEE RECORDS UNDER CODE OF CIVIL PROCEDURE SECTION 1985.3 OR 1985.6 AND A MOTION TO QUASH OR AN OBJECTION HAS BEEN SERVED ON YOU, A COURT ORDER OR AGREEMENT OF THE PARTIES, WITNESSES, *AND* CONSUMER OR EMPLOYEE AFFECTED MUST BE OBTAINED BEFORE YOU ARE REQUIRED TO PRODUCE CONSUMER OR EMPLOYEE RECORDS.**

DISOBEDIENCE OF THIS SUBPOENA MAY BE PUNISHED AS CONTEMPT BY THIS COURT. YOU WILL ALSO BE LIABLE FOR THE SUM OF FIVE HUNDRED DOLLARS AND ALL DAMAGES RESULTING FROM YOUR FAILURE TO OBEY.

Date issued: July 27, 2016
Michael Roddy
(TYPE OR PRINT NAME)

(SIGNATURE OF PERSON ISSUING SUBPOENA)

CLERK OF THE COURT
(TITLE)

(Proof of service on reverse)

Form Adopted for Mandatory Use
Judicial Council of California
SUBP-010 [Rev. January 1, 2012]

DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

Code of Civil Procedure, §§ 2020.410–2020.440;
Government Code, § 68097.1
www.courts.ca.gov

PLAINTIFF/PETITIONER: Melissa Escalera DEFENDANT/RESPONDENT: Sharp Healthcare, et. al.	CASE NUMBER: 37-2016-00017392

PROOF OF SERVICE OF DEPOSITION SUBPOENA FOR PRODUCTION OF BUSINESS RECORDS

1. I served this *Deposition Subpoena for Production of Business Records* by personally delivering a copy to the person served as follows:
   a. Person served *(name)*:

   b. Address where served:

   c. Date of delivery:

   d. Time of delivery:

   e. (1) ☐ Witness fees were paid.
   Amount: . . . . . $ _____
   (2) ☐ Copying fees were paid.
   Amount: . . . . . $ _____

   f. Fee for service: . . . . . $ _____

2. I received this subpoena for service on *(date)*:

3. Person serving:
   a. ☐ Not a registered California process server.
   b. ☐ California sheriff or marshal.
   c. ☐ Registered California process server.
   d. ☐ Employee or independent contractor of a registered California process server.
   e. ☐ Exempt from registration under Business and Professions Code section 22350(b).
   f. ☐ Registered professional photocopier.
   g. ☐ Exempt from registration under Business and Professions Code section 22451.
   h. Name, address, telephone number, and, if applicable, county of registration and number:

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Date:

▶ _____
(SIGNATURE)

(For California sheriff or marshal use only)
I certify that the foregoing is true and correct.

Date:

▶ _____
(SIGNATURE)